PHYSICIAN'S STATEMENT

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES
DIVISION OF CHILD CARE
275 EAST MAIN ST. 3 C-F, FRANKFORT, KY 40621

CERTIFICATION PROGRAM FOR CHILD CARE PROVIDER

Child Care Provider's Name:_____

Address/City/State:_____

Telephone Number:_____

The above named person has applied to become a state certified family child care home provider. This person will be solely responsible for the care of up to six (6) unrelated children in addition to related children. She/he will be working an average of eight (8) to the (10) hours per day, five (5) days per week.

In your medical opinion, is this person physically capable of assuming these job responsibilities.

YES _____ NO _____

If no, who not? _____

_____

_____

Any additional comments:_____

_____

_____

_____ _____
Physician's Signature Date

Physician's Name (please print) _____

Office Address _____

City _____ State _____ Telephone _____